STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING 00 B. WING	07/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 E 86TH ST INDIANAPOLIS, IN 46256

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F0000	This visit was for a Recertification and State Licensure Survey. This visit included Investigation of Complaint IN00110834. Complaint IN00110834 - Substantiated. No deficiencies related to the allegation(s) are cited. Survey dates: July 9, 10, 11, & 12, 2012 Facility number: 000149 Provider number: 155245 AIM Number: 100266840 Survey team: Lora Brettnacher, RN-TC Connie Landman, RN Diana Zgonc, RN Christi Davidson, RN Census bed type: SNF/NF: 59 Total: 59 Census payor type: Medicare: 10 Medicaid: 39 Other: 10 Total: 59	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on July 17, 2012 by Bev Faulkner, RN			

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F0371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure proper kitchen hand washing and failed to ensure proper hand washing between serving resident meal trays which had the potential to effect 56 of 59 residents that receive meal trays from the kitchen. (Cook #1, Cook #2, LPN [Licensed Practical Nurse] #3, AA [Activity Aide] #4, RNA [Restorative Nurse Aide] #5, CNA [Certified Nursing Aide] #6) Findings include: 1. During a kitchen observation on 7/9/12 at 11:16 a.m., Cook #1 washed their hands in one of the kitchen hand washing sinks and was observed turning the water faucet off with a bare hand and then dried their hands with paper towel. 2. During a kitchen observation on 7/9/12 at 11:20 a.m., Cook #2 left the food service line, went to the back of the kitchen, went into the dry storage	F0371	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; It is the policy of this facility to ensure proper kitchen hand washing and to ensure proper hand washing between serving resident meal trays. Cook #1 has been in-serviced to use a dry paper towel to dry hands. Then use another dry paper towel to turn off hand washing sink faucet after washing hands. Cook #2 has been in-service as to whenever he leaves the serving line to wash his hands prior to stepping back on line. LPN #3 has been educated as not to butter resident's bread using her bare hands. LPN #3 has also been educated as to use hand gel between resident's meal trays. AA#4 has been educated as to use hand gel after touching a resident or putting a clothing protector on a resident prior to touching another resident. RNA #5 has also been educated to use hand gel in between passing residents meal trays. CNA #6 has been educated to use had gel in between resident to resident	08/02/2012

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	room and returned to the food service line without washing hands. Cook #2 was observed placing covers on plates, adding butter pats to trays, adding ice cream cups to trays and adding milk cartons to trays. During an interview on 7/9/12 at 11:30 a.m., the Dietary Manager indicated the faucet should be turned off with a paper towel, and Cook #2 should have washed hands when returning to the food service line. 3. During a dining observation on 7/9/12 at 11:35 a.m., LPN #3 touched a resident's slice of bread with bare hands then proceeded to serve other residents' meal trays in the main dining area without washing hands or using hand gel. LPN #3 removed plastic wraps from cake, removed lids from cups, cut a resident's sandwich in half while holding the knife in one hand and the sandwich in the other, buttered a resident's potatoes, and continued serving residents' meal trays without washing hands or using hand gel between tasks in the main dining area. Sixteen (6) residents were observed in the main dining area for the lunch meal. A hand gel dispenser was observed on the wall outside the kitchen next to where the tray cart was parked that contained		contact. The ADON was also reminded that she should use had gel in between resident to resident contact. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents have the potential to be affected by this practice. The DON or designee will monitor each dining room (3) times weekly to ensure that all staff are using proper hand washing or hand gel in between resident meal trays. Also the Dietary manager will monitor weekly (3) meal times "Food line production from beginning to end" to ensure proper hand washing with staff. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; At an all staff in-service held on July 31, 2012 the proper techniques of hand washing and using hand gel while providing resident assistance at meal times was discuss. Also meal tray line serving when leaving the food line you must wash your hands upon returned was discussed. Any staff who fail to follow the outlined in-service will be progressively disciplined up to and including termination. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put	

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	residents' meal trays. 4. During a dining observation on 7/9/12 at 11:35 a.m., AA #4 put a clothing protector on a resident, then proceeded to serve other residents' meal trays in the main dining area without washing hands or using hand gel. AA #4 cut up a resident's meat and continued to serve multiple resident trays without washing hands or using hand gel. Sixteen (16) residents were observed in the main dining area for the lunch meal. A hand gel dispenser was observed on the wall outside the kitchen next to where the tray cart was parked that contained residents' meal trays. 5. During a dining observation on 7/9/12 at 11:35 a.m., RNA #5 cut up a resident's meat, rubbed a resident's back and proceeded to serve other residents' meal trays in the main dining area without washing hands or using hand gel. Sixteen (16) residents were observed in the main dining area for the lunch meal. A hand gel dispenser was observed on the wall outside the kitchen next to where the tray cart was parked that contained residents' meal trays. 6. During a dining observation in the Main Dining Room on 7/9/12 at 11:40		into place: and by what date the systemic changes will be completed. At the monthly quality assurance meeting all monitoring(s) of resident meals and food line serving will be discuss. Any negative patterns from the findings the Administrator shall appoint a quality review team to follow until 100% compliance is met.	

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	A.M., CNA (Certified Nursing Assistant) #6 assisted a resident with cutting their food, rubbed another resident's back, buttered another resident's bread, helped another resident with unwrapping their silverware, passed drinks to another resident taking the paper covers off the lids. During this dining observation CNA #6 did not wash or sanitize her hands between resident to resident contact. During this dining observation, the ADON (Assistant Director of Nursing) assisted a resident with their clothing protector, patted another resident's arm, shook another resident's hand, then put sugar in another resident's coffee. The ADON did not wash or sanitize her hands between resident to resident contact. The hand gel container was observed hanging on the wall in the Main Dining Room. A current policy titled "Handwashing Procedure" provided by the ADON (Assistant Director of Nursing) on 7/11/2012 at 4:34 P.M. was reviewed on 7/12/2012 at 3:15 P.M. This policy indicated, "Handwashing was the single most important measure for preventing the spread of illness and all employees should wash his/her hands routinely after each direct resident contact (as indicated by			

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	accepted professional practice) and after handling contaminated articles. . . . instances when hand washing should be done included before and after caring for each patient and before returning to the tray-line if you leave the tray-line. The policy further indicated staff should remember when a resident's body is weakened by illness of any kind, even his/her own germs can be a danger to him/her. It is their responsibility to minimize the spread of germs in the nursing facility by keeping the resident and his/her surroundings and yourself as clean and free of germs as possible". 3.1-21(i)(3)			

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F0441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review, the facility failed to	F0441	What corrective action(s) will be accomplished for those residents	08/02/2012

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	ensure proper hand washing during a medication pass for 1 of 10 residents observed for medication administration. Resident # 46. Findings include: During a medication observation on 7/11/12 at 10:15 a.m., RN [Registered Nurse] #7 and RN #8 did not wash their hands upon entering Resident #46's room. RN #7 and RN #8 donned gloves. RN #7 stopped the enteral feedings. RN #7 checked the feeding tube for residual contents. RN #7 spilled the crushed medications that were mixed in water. RN #7 cleaned up the spilled medications, administered the liquid medications and then capped the feeding tube. RN #8 was instructing RN #7 on the procedure. RN #7 and RN #8 took off their gloves and exited Resident #46's room without washing their hands or using hand gel. RN #7 re-pulled from the medication cart the medications that were spilled. RN #7 and RN #8 re-entered Resident #46's room and donned gloves without washing their hands or using hand gel. RN #7 administered the crushed medications by way of the feeding tube. During an interview on 7/11/12 at		found to have been affected by the deficient practice; RN #7 and RN #8 were both re-educated on the hand washing policy and to wash their hand prior and after giving resident care. Resident #46 had no adverse reaction to the lack of their hand washing. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this practice. The DON or designee will monitor LPN/RN/CNA three times weekly monitoring each shift at least once to ensure proper hand washing is taking place according to the hand washing policy. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; At an all staff in-service held July 31, 2012 the Hand Washing Policy and Procedure was reviewed. Any staff who fail to follow the Hand Washing Policy and Procedure will be progressively disciplined up to and including termination. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, iel, what quality assurance program will be put into place; At the monthly quality assurance meeting all monitoring from the hand washing observations will be reviewed. Any negative patterns will be discuss. If	

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	11:00 a.m., RN #7 and RN #8 indicated they should have washed their hands upon entering and exiting Resident #46's room. During an interview on 7/11/12 at 4:20 p.m., the ADON was requested to provide a policy on hand washing, and indicated she would expect staff to wash their hands when entering or exiting a resident's room. A facility policy provided by the ADON on 7/11/12 at 4:34 p.m., indicated, "...Handwashing is the single most important measure for preventing the spread of illness...The employee should wash his/her hands routinely after each direct resident contact (as indicated by accepted professional practice) and after handling contaminated articles...4. Before and after caring for each patient...12.) before Putting (sic) gloves on, and in between putting New (sic) gloves on." 3.1-18(l)		necessary the Administrator shall appoint a quality review team to monitor until 100% compliance his reached.	